DEPARTMENT OF HEALTH AND HUMAN SERVICES YOST PRINTED: 06/19/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 445099 NAME OF PROVIDER OR SUPPLIER 05/23/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NHC HEALTHCARE, ATHENS 1204 FRYE ST ATHENS, TN 37303 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 000 INITIAL COMMENTS F 000 This plan is submitted as required Statement of Deficiencies AMENDED 06/19/12. F 164 483.10(e), 483.75(I)(4) PERSONAL under State and Federal Law. The F 164 SS=D PRIVACY/CONFIDENTIALITY OF RECORDS submission of this plan does not constitute an admission on the part The resident has the right to personal privacy and of NHC Healthcare, Athens as to the confidentiality of his or her personal and clinical accuracy of the Surveyor's findings records. nor the conclusions drawn there Personal privacy includes accommodations, from. The facility's submission of the medical treatment, written and telephone Plan of Correction does not communications, personal care, visits, and constitute an admission on the part meetings of family and resident groups, but this of the facility that the findings does not require the facility to provide a private constitute a deficiency, or that the room for each resident. scope and severity regarding any of Except as provided in paragraph (e)(3) of this the deficiencies cited are correctly section, the resident may approve or refuse the applied. release of personal and clinical records to any individual outside the facility. 1. Facility will attain proper The resident's right to refuse release of personal authorization before releasing and clinical records does not apply when the medical records from patient/ resident is transferred to another health care family/ or legal representative for institution; or record release is required by law. resident #1. The facility must keep confidential all information 2. Record review indicates no other contained in the resident's records, regardless of residents found to be affected by the form or storage methods, except when the same occurrence. release is required by transfer to another 3. The facility will attain proper healthcare institution; law; third party payment release of information from patient/ contract; or the resident. family/ or legal representative before releasing medical records. This REQUIREMENT is not met as evidenced Health Information, Social Services, by: and Nursing administration will be

ABORATIONY DIRECTOR'S OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

the facility failed to provide confidentiality of

Based on medical record review and interview,

TITLE

(X6) DATE

iny deficency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

in-serviced on proper procedures for

releasing medical information.

DEPAR	TMENT OF HEALTH RS FOR MEDICARE	HAND HUMAN SERVICES & MEDICAID SERVICES				FORM	D: 06/19/201 MAPPROVEI
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Section 2	ULTIPL	E CONSTRUCTION	(X3) DATE :	
		445099	B. WI	concerc. /•)	C
	PROVIDER OR SUPPLIER ALTHCARE, ATHENS		1	120	ET ADDRESS, CITY, STATE, ZIP COI 4 FRYE ST HENS, TN 37303		23/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	The findings included Resident #1 was and February 27, 2007, on April 14, 2012, where Medical record revied (MDS) dated Septemental cognitive skills, no more behaviors. Medical record revied (MDS) dated Septemental record fifter Interview for Mental cognitive skills, no more behaviors. Medical record revied transferred from the hospital on April 11, Acute Renal Failure resident was dischard April 14, 2012, follow Medical record revied note, from the local hat 5:40 p.m., revealed pts (patients) daught NHC (National Health Interview with the Adat 12:05 p.m., in the confirmed when the resident want the resident home facility following the state of	Imitted to the facility on and readmitted to the facility with diagnoses including Quadriplegia, Depression, er, and Pylonephritis. Ew of the Minimum Data Set mber 1, 2011, revealed the en of fifteen on the Brief Status (BIMS) with intact nemory impairment, and no ew revealed resident #1 was facility and admitted to the 2012, with diagnoses of and Pyelonephritis. The reged back to the facility on wing a three day hospital stay. W of a Discharge Planner nospital, dated April 13, 2012, d "verbal permission from the red propose of the permission from the red propose of the permission from the red propose of the permission from the red permissio	F1	64	4. Administrator/design review with Social Service Department Head to ensure procedures were followed release of medical recompatients that transferred facility once a month for months. Findings will be the monthly QA meeting by Administrator, DON, A Social Services, and Med Director.	ses sure proper ed for the ds for I out of the three reported at attended ADON,	G/30/12

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DEPAR	RS FOR MEDICARI	H AND HUMAN SERVICES		PR	INTED: 06/19/201 FORM APPROVE
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	IPLE CONSTRUCTION (X3)	MB NO. 0938-039 DATE SURVEY COMPLETED
		445099	B. WING		c
NAME OF	PROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, ZIP CODE	05/23/2012
	EALTHCARE, ATHENS		1:	204 FRYE ST ATHENS, TN 37303	
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F 164	placement at the oth	me facility regarding possible her facility.	F 164		
	office, confirmed the information had bee nursing home on Applacement in the oth resident nor family hopermission for clinical	ocial Service Director on May m., in the Social Service e resident's clinical en faxed to another local oril 13, 2012, for possible ner facility, and neither the nad not requested or given cal information to be sent.		 Resident #1/ family/ legal representative will be given a phocal followed by a written notice of the bed-hold policy within twents four hours of a future transfer to hospital. Record review indicates no other nations were found to be affected. 	of y- the
SS=D	Before a nursing faci hospital or allows a releave, the nursing faci information to the resor legal representative of the bed-hold policy during which the residence and resume residence the nursing facility's periods, which must be (b)(3) of this section, return.	resident to a resident to a resident to go on therapeutic cility must provide written sident and a family member we that specifies the duration y under the State plan, if any, ident is permitted to return ce in the nursing facility, and policies regarding bed-hold be consistent with paragraph permitting a resident to	F 205	patients were found to be affected by the same occurrence. 3. When patients are transferred the hospital, the patient/ family/ legal representative will be given phone call followed by a written notice of the bed-hold policy with twenty-four hours of admission to the hospital. 4. Administrator/designee will review all transfers to the hospital monthly to ensure that a phone of followed by a written twenty-four hour notice of bed-hold policy was sent to the patient/ family/ or legal	I to or a nin o
1	member or legal repre	or of a resident for rapeutic leave, a nursing to the resident and a family resentative written notice uration of the bed-hold policy		representative for three months. Findings will be reported at the monthly QA meeting attended by Administrator, DON, ADON, Social	

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described in paragraph (b)(1) of this section.

This REQUIREMENT is not met as evidenced

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6/30/12

Services, and Medical Director.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/19/2012 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445099 05/23/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1204 FRYE ST NHC HEALTHCARE, ATHENS ATHENS, TN 37303 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 205 Continued From page 3 F 205 Based on medical record review, review of facility documentation, and interview, the facility failed to provide written notice of the bed-hold policy within twenty-four hours of a transfer for one resident (#1) of seven residents reviewed. The findings included: Resident #1 was admitted to the facility on February 27, 2007, and readmitted to the facility on April 14, 2012, with diagnoses including Multiple Sclerosis, Quadriplegia, Depression, Suprapubic Catheter, and Pylonephritis. Medical record review of the Minimum Data Set (MDS) dated September 1, 2011, revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) with intact cognitive skills, no memory impairment, and no behaviors. Medical record review revealed resident #1 was transferred from the facility and admitted to the hospital on April 11, 2012, with diagnoses of Acute Renal Failure and Pyelonephritis. The

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resident was discharged back to the facility on April 14, 2012, following a three day hospital stay.

Medical record review and review of facility documentation revealed no documentation the resident or the resident's representative had been given written notice of the facility's bed-hold policy within 24 hours of admission to the hospital.

Interviews with the Social Service Director on May 22, 2012, at 4:15 p.m., and 4:45 p.m., in the Social Service office, confirmed a family member

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	ND HUMAN SERVICES			TOTAL	: 06/19/201
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NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	05/2	23/2012
NHC HEALTHCARE, ATHENS			1204 FRYE ST ATHENS, TN 37303		
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Interview with the Admi at 12:05 p.m., in the Ad confirmed the facility fa notice within twenty-four hospital of the bed hold C/O #29799 F 246 SS=D OF NEEDS/PREFEREI A resident has the right services in the facility waccommodations of ind	ified verbally by the ent had no bed hold days, admitted to the hospital. inistrator on May 23, 2012, Iministrator's office, illed to provide a written in hours of transfer to the policy. ABLE ACCOMMODATION NCES to reside and receive rith reasonable ividual needs and en the health or safety of esidents would be s not met as evidenced and review and interview, remmodate individual mediate	F 24	1. All equipment used with #1, is currently in prime work condition. If equipment is for the malfunctioning, a work of the filled out immediately and Administrator or designee with notified. The DME Company notified to reserve backup equipment until malfunction	rking bund to order will od vill be vill be ound to currence. out work unction ds will be ended oN, Dietary. ignee unction ry istrator, Director,	4/30/12

DEPAR CENTE	TMENT OF HEALTH	H AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	D: 06/19/201 M APPROVE
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	(MDS) dated Septer resident scored fifte Interview for Mental cognitive skills, no number behaviors. Continue the resident required transfers, eating, and (ADLS). Medical record review Plan, dated May 10, on staff for ADLS r/t secondary to Multiply have all daily needs person transfer w/ (ww/c (wheelchair) with (television) controls assist of two persons changes in bed and meals dailyrepositi is unable to make even unassistedresident met daily without excelled the Maxi Lift needed to be moved.	ew of the Minimum Data Set Imber 1, 2011, revealed the Been of fifteen on the Brief I Status (BIMS) with intact Imemory impairment, and no led review of the MDS revealed do total staff assistance for all and activities of daily living Indicativities Indicativi	F 246			

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been repaired until May 17, 2012. Further interview revealed the resident's electric chair would recline for sleeping and the resident stayed in the electric wheelchair from May 12, through May 17, 2012. Further interview revealed the resident did not use a facility supplied bed or mattress; the height of the resident's personal bed did not adjust and the Arjo lift (the facility's

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/19/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445099 05/23/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NHC HEALTHCARE, ATHENS 1204 FRYE ST ATHENS, TN 37303 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 246 Continued From page 6 F 246 other mechanical lift) did not go up high enough to place the resident in the resident's bed. Further interview revealed the Administrator offered on the third or fourth day to change the resident's bed to a facility supplied bed, and the resident requested the resident's mattress be placed on the facility bed, but staff never changed the bed. Further interview confirmed the resident had not been offered another alternative. Interview with Certified Nurse Assistant (CNA) #1 on May 22, 2012, at 2:45 p.m., in the Nurse's Station, revealed the resident had been in the electric wheelchair from May 12, 2012, through May 17, 2012, and had not been placed in the resident's bed at night due to the Arjo Lift would not raise the resident high enough to place the resident on the resident's bed. Continued interview revealed the Arjo Lift would allow the staff to provide all ADLS the only change in routine care from May 12, 2012, through May 17, 2012, was the resident was not able to lie down on the resident's bed. Interview with Licensed Practical Nurse (LPN) #1

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on May 22, 2012, at 3:15 p.m., in the Activity Room, confirmed the Maxi Lift broke on May 12, 2012, at 3:00 p.m., and was not operational until May 17, 2012, sometime in the morning. Further interview revealed the facility attempted to contact the Administrator and the Maintenance Director regarding the broken Maxi Lift and did not receive a return call on May 12 or May 13, 2012. Further interview confirmed the broken mechanical lift was the lift required to put resident #1 to bed, the resident was not offered any alternatives (manual lift or bed options) over the weekend and the resident stayed up in the electric wheelchair from

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/19/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED C B. WING 445099 05/23/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NHC HEALTHCARE, ATHENS 1204 FRYE ST ATHENS, TN 37303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 246 Continued From page 7 F 246 May 12 through May 17, 2012. Interview with CNA #2 on May 23, 2012, at 9:15 a.m., in the Conference Room, revealed the Maxi Lift was broken when the CNA arrived at work on May 14, 2012, staff reported to the CNA the Maxi Lift had been broken since May 12, 2012, and the resident had been in the chair since May 12, 2012. Continued interview revealed the Arjo Lift had been in place, staff had been using the Arjo Lift to provide routine care, and the Arjo Lift would not raise the resident high enough to place the resident on the resident's bed. Further interview confirmed, on May 15, 2012, the Administrator offered to change the resident's bed to a facility bed so the resident could lie down, and the resident requested own personal mattress be placed on the facility bed, but nothing had been changed. Interview with CNA #3 on May 22, 2012, at 3:05 p.m., in the Activity Room, confirmed the resident required total care, while the Maxi Lift was broken the resident stayed in the electric chair all day, staff repositioned the resident, staff performed routine care with the Arjo Lift, but staff had not been able to lie the resident down in bed. Interview with the Administrator on May 22, 2012, at 11:30 a.m., in the Administrator's office, confirmed the mechanical lift was broken May 12,

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C/O #29799

through 17, 2012, the resident had stayed in the chair without going to bed from May 12, 2012, through May 17, 2012, and the facility did not accommodate the resident's needs for five days.

F 250 483.15(g)(1) PROVISION OF MEDICALLY

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		I AND HUMAN SERVICES & MEDICAID SERVICES				FORM): 06/19/2012 APPROVED
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	services to attain or practicable physical well-being of each resident services. This REQUIREMENT by: Based on medical resident facility failed to prove to meet the needs of seven residents revent of the findings included resident #1 was addicted february 27, 2007, on April 14, 2012, we multiple Sclerosis, Continued to the seven resident scored fifted interview for Mental cognitive skills, no metal cognitive skills, no me	ovide medically-related social maintain the highest mental, and psychosocial esident. IT is not met as evidenced record review, observation, w of facility investigation, the ide Social Services adequate of two (#1, #5) residents of iewed. It is not met as evidenced record review, observation, w of facility investigation, the ide Social Services adequate of two (#1, #5) residents of iewed. In it is not met as evidenced record review, observation, the ide Social Services adequate of two (#1, #5) residents of iewed. It is not met as evidenced record review of the facility on and readmitted to the facility on and readmitted to the facility ith diagnoses including Quadriplegia, Depression, r, and Pylonephritis. It is not met as evidenced record review of the facility on and readmitted to the facility on and readmitted to the facility ith diagnoses including Quadriplegia, Depression, r, and Pylonephritis. It is not met as evidenced record reviewed.	F:	250	 Social Services Director with Resident #1 to discuss psychosocial issues or concressident #5 is no longer a pthis facility. No further patients were by the same occurrence. In weekly interdisciplinal meeting all clinical and psy issues or concerns will be defended. Administrator/ DON and Service Director/designee with monitor psychosocial issue concerns to ensure patient are met with Social Service intervention and findings with discussed at the weekly interdisciplinary meeting at by Administrator, DON, AD Social Services Director, and 	e any cerns. coatient at e affected ary chosocial liscussed. d Social will s or 's needs vill be ttended ON,	4/30/12
		w of an Interdisciplinary Care 2012, revealed "dependent					

on staff for ADLS r/t (related to) quadriplegia

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PRINTED: 06/19/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445099 05/23/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1204 FRYE ST NHC HEALTHCARE, ATHENS ATHENS, TN 37303 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 250 Continued From page 9 F 250 secondary to Multiple Sclerosis...resident will have all daily needs for ADL, met by staff...provide oral care...two person transfer w/ (with) total body lift to electric w/c (wheelchair) with chin control for mobility, tv (television) controls and computer access...total assist of two persons for toileting and position changes in bed and w/c...unable to utilize hand toggle switch independently...staff to totally assist with meals daily...reposition frequently as pt (patient) is unable to make even slight changes unassisted...residents needs and wants will be met daily without excess demands...meet residents needs and wants as much as possible but set limits...tell (resident)...how many minutes may be spent before beginning, that you may return later if needed, whether care can be done as (resident) requests...Inappropriate Behavior AEB (as exemplified by) attempted manipulation and control of staff and family, demanding and impatient, verbally sharp w/ caregivers...Anxiety AEB easily frustrated, repetitive health complaints, anxious concerns, insomnia, unpleasant mood in the mornings, social isolation..."

Medical record review revealed no Social Services Notes from January 2012, through May 22, 2012, related to any concerns, meetings, or needs.

Observation of the resident on May 22, 2012, at 9:10 a.m., in the resident's room, revealed the resident in an electric wheelchair, with chin control for television control, call light, remote fan, computer with whisper software, and head piece for volume. Interview with the resident, at this time, confirmed the resident had expressed

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DEPAR CENTE	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	0: 06/19/2012 1 APPROVED 0: 0938-0391
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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CIT	Y, STATE, ZIP CODE	1 00//	23/2012
NHC HE	ALTHCARE, ATHENS			1204 FRYE ST ATHENS, TN 3730	03		
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	Administration related provided and the factoresident's needs or concerns. Continue Social Worker of the the resident or attent the resident's concerns. Interview with the Sc 22, 2012, at 4:45 p.r office, confirmed the aware of the facility regarding the resident the resident and the was recommending placement; and the fresident back after a Continued interview Social Worker had not resident or provided "Administrator had had Regional Vice President to the resident that continued interview with the Ad Regional Vice President to the resident had continued interview with the Ad Regional Vice President to the resident had continued interview with the Ad Regional Vice President to the resident had continued interview with the Ad Regional Vice President to the resident had continued interventions attempting to respect to the resident had continued interventions attempting to respect to the resident had continued interventions attempting to respect to the resident had continued interventions attempting to respect to the resident had continued interventions attempting to respect to the resident had continued interventions attempting to resident had continued interventions.	neetings with the facility ed to personal care not being cility not meeting the addressing the resident's ed interview confirmed the e facility had not visited with ded any meetings discussing rns related to personal care ocial Service Director on May m., in the Social Service e Social Worker had been meetings with the resident nt and family concerns nt's care; the facility informing resident's family the facility discharge home or other facility's refusal to take the transfer to the hospital, at this time confirmed the ot had any contact with the any services to the resident	F2	50			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
	9.	445099	B. WIN	IG	—) 05/2	C 23/2012	
	PROVIDER OR SUPPLIER ALTHCARE, ATHENS			STREET ADDRESS, CITY, STATE, ZI 1204 FRYE ST ATHENS, TN 37303			
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F 250	2012, revealed an a had occurred in the 6:00 p.m., in which a family member. It member "slapped an attempt to wake member could feed meal. Interview with the S 2012, at 10:00 a.m. office, confirmed the investigated by the Worker had not bee investigation and had or the resident's famphysical abuse to as needs or intervention. Interview with the A at 10:15 a.m., in the the facility failed to it consultation/case reto the allegation of p	investigation dated May 16, allegation of physical abuse facility on May 15, 2012, at resident #5 was being fed by was alleged the family (the resident) in the face" in the resident, so the family the resident the evening ocial Worker on May 23, outside the Social Worker's e incident had been Administrator and the Social	F 2	250			
F 312 SS=D	C/O #29799 C/O #29814 483.25(a)(3) ADL C/ DEPENDENT RESI	ARE PROVIDED FOR DENTS	F 3 ⁻	12			
	daily living receives	able to carry out activities of the necessary services to ion, grooming, and personal					

		TH AND HUMAN SERVICES RE & MEDICAID SERVICES			FOR	D: 06/19/201: M APPROVE
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	9 2000 1000 170	MULTIPLE CONSTRUCTION	(X3) DATE	O. 0938-039 SURVEY PLETED
		445099	B. WIN	NG	—)	C (12212042
	PROVIDER OR SUPPLIER EALTHCARE, ATHENS			STREET ADDRESS, CITY, STATE, ZII 1204 FRYE ST ATHENS, TN 37303		3/23/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 312	Continued From pa	age 12	F 3	312		
	by: Based on medical the facility failed to resident (#1) of several the facility failed to resident (#1) of several the findings included Resident #1 was at February 27, 2007, on April 14, 2012, while the Science of Suprapubic Catheter (MDS) dated Septement of Medical record reviews for Mental cognitive skills, nor behaviors. Continual revealed the resident scored fifted Interview for Mental cognitive skills, nor behaviors. Continual revealed the resident assistance for all transfer of daily living (ADLS) Medical record reviews Plan, dated May 10, on staff for ADLS resecondary to Multiple have all daily needs staffprovide oral cowants will be met date demandsmeet resident)how mare before beginning, the	idmitted to the facility on and readmitted to the facility with diagnoses including Quadriplegia, Depression, ter, and Pylonephritis. Diew of the Minimum Data Set ember 1, 2011, revealed the een of fifteen on the Brief al Status (BIMS) with intact memory impairment, and no used review of the MDS ent required total staff ansfers, eating, and activities S). Diew of an Interdisciplinary Care of the Company of the MDS ent required total staff ansfers, eating, and activities S). Diew of an Interdisciplinary Care of the MDS ent required total staff ansfers, eating, and activities S). Diew of an Interdisciplinary Care of the MDS ent regulated to the MDS ent required total staff ansfers, eating, and activities S).		1. DON/ designee we Resident #1 has oral 2. No other patients be affected by the sa 3. Staff will be in-set oral care for all resid designee will monitor patients monthly for 4. Social Services Die with Resident #1 one weeks to discuss issuand findings will be rein the interdisciplina attended by Administ ADON, Social Services Dietary.	care daily. s were found to ame occurrence. rviced on daily lents. DON/ or 10% of three months. rector will meet ce a week for 8 ues or concerns reviewed weekly ry meeting strator, DON,	6/30/12

	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BŲI B. WII		IĢ		C
		445099	B. WII	<u> </u>		05/2	3/2012
*	PROVIDER OR SUPPLIER ALTHCARE, ATHENS			1:	REET ADDRESS, CITY, STATE, ZIP CODE 204 FRYE ST ATHENS, TN 37303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	9:10 a.m., and 3:30 revealed the the rest brush my teeth eve Further interviews of were brushed on M Nursing Assistant (of there were days who get brushed because Interviews with CNA p.m., at the nurse's 22, 2012, at 3:05 p. with Licensed Pract 2012, at 3:15 p.m., confirmed the residlenger to perform the frequently had to limperforming the resident's personal of the complete other task Interview with CNA a.m., in the conference ident's personal of the conference identification	resident on May 22, 2012, at p.m., in the resident's room, sident stated "staff do not rydaythey run out of time" confirmed the resident's teeth ay 22, 2012, by Certified CNA) #2 and a student, but ten the resident's teeth did not se the CNAs did not have time. A #1 on May 22, 2012, at 2:45 station, with CNA #4 on May m., at the nurse's station, and tical Nurse #1 on May 22, at the nurse's station, ent's personal care took an other residents and staff nit the amount of time spent dent's care in order to a sand care for other residents. #2 on May 23, 2012, at 9:15 nice room, confirmed the care took longer to perform and the resident's teeth did	F	312			
F 456	C/O #29799 483.70(c)(2) ESSEN OPERATING CONE	NTIAL EQUIPMENT, SAFE	F 4	56			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING	(X3) DATE SI COMPLE	
		445099	B. WING	·	N	C 3/2012
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 1204 FRYE ST ATHENS, TN 37303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 456	mechanical, electric equipment in safe This REQUIREME by: Based on medical the facility failed to transfer a resident condition for one reviewed. The findings included Resident #1 was a February 27, 2007 on April 14, 2012, Multiple Sclerosis, Suprapubic Cather (MDS) dated Septement of Medical record reviewed for Mentacognitive skills, no behaviors. Continuation transfers, eating, a (ADLS). Medical record reviewed Plan, dated May 10 on staff for ADLS resident safe.	naintain all essential ical, and patient care operating condition. INT is not met as evidenced record review and interview, ensure equipment required to was maintained in working esident (#1) of seven residents led: Idmitted to the facility on and readmitted to the facility with diagnoses including Quadriplegia, Depression, ter, and Pylonephritis. Iew of the Minimum Data Set ember 1, 2011, revealed the een of fifteen on the Brief al Status (BIMS) with intact memory impairment, and no led review of the MDS revealed ed total staff assistance for all and activities of daily living liew of an Interdisciplinary Care 0, 2012, revealed "dependent of the related to) quadriplegia	F 45	1. If equipment is found malfunctioning, a work of illed out immediately an Administrator or designe notified. The DME Companotified to reserve backuequipment until malfunctequipment is repaired. 2. No other patients were be affected by the same of affected by the same of a staff will be in-service proper procedure for filling orders when equipment malfunctioning. Any issue concerning equipment mand accommodation of a discussed at the weekly interdisciplinary meeting by Administrator, DON, A social Services Director, and Administrator, DON, will review any work order concerning equipment main the daily morning mee attended by Administrator.	rder will be d e will be any will be p tioning e found to occurrence. d on the ng out work is es alfunction eeds will be attended DON, and Dietary. designee ers alfunction ting or, DON,	1. /2.0/12
	secondary to Multiphave all daily need	/t (related to) quadriplegia ple Sclerosisresident will s for ADL, met by stafftwo (with) total body lift to electric		ADON, Social Services Die Dietary.		6/30/12

PRINTED: 06/19/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUI)	c
		445099	B. WIN	G		05/2	3/2012
	ROVIDER OR SUPPLIER			12	EET ADDRESS, CITY, STATE, ZIP CODE 204 FRYE ST THENS, TN 37303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	toileting and position w/creposition free to make even slight unassistedresided met daily without existed in the resident daily without existed to be moved to be an are paired until interview revealed to be moved to be an are paired until interview revealed would recline for skin the electric whee May 17, 2012. Furnesident did not used mattress; the heigh bed did not adjust a other mechanical lift to place the resident litto place the resident litto place the resident litto place the resident day. Furth written order had be no purchase order Maintenance Direct Interview with Certifon May 22, 2012, a Station, revealed the side of the station of the side	otal assist of two persons for in changes in bed and quently as pt (patient) is unable to changes into needs and wants will be kneeds and wants will be kneeds and wants will be kneeds demands" esident on May 22, 2012, at in p.m., in the resident's room, with the chanical lift resident and chair on May 12, 2012, and had not May 17, 2012. Further the resident's electric chair deping and the resident stayed elichair from May 12, through the interview revealed the end a facility supplied bed or to of the resident's personal and the Arjo lift (the facility's fit) did not go up high enough the in the resident's bed. Italiantenance Director on May a.m., in the maintenance verbal request to repair the labeen broken, was received to Director on one day y) and the lift had been fixed er interview confirmed no deen completed by the staff and had been completed by the	F4	156			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HI5611

Facility ID: TN5404

If continuation sheet Page 16 of 18

DEPARTMENT OF HEALTH AND HUMAN SERVICES							D: 06/19/2012 M APPROVED
		E & MEDICAID SERVICES					D. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE S	SURVEY
	90	445099	B. WIN	G		05/	23/2012
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP COD		2012012
NHC HE	ALTHCARE, ATHENS	3			04 FRYE ST THENS, TN 37303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	resident's bed at ni not raise the resider resident on the resider resident routine care from M 2012, was the resident's be confirmed three off their normal care d Interview with Licer on May 22, 2012, a Room, confirmed the 2012, at 3:00 p.m., May 17, 2012, som interview revealed the Administrator a regarding the broke a return call on May interview confirmed was the lift required resident was not off lift or bed options) or resident stayed up in May 12, 2012 through Interview with CNA a.m., in the Conferent Lift was broken whe May 14, 2012, staff Lift had been in place, so Lift to provide routin had been in place, so Lift to provide routin staff to provide routin not resident was not off lift or bed options) or resident stayed up in May 12, 2012 through Interview with CNA a.m., in the Conferent Lift was broken when May 14, 2012, staff Lift had been in place, so Lift to provide routin not resident had been in place, so Lift to provide routin not resident had been in place, so Lift to provide routin not resident had been in place, so Lift to provide routin not resident had been in place, so Lift to provide routin not resident had been in place, so Lift to provide routin not resident had been in place, so Lift to provide routin not resident had been in place, so Lift to provide routin not resident had been in place, so Lift to provide routin not resident had been in place, so Lift to provide routin not resident had been in place, so Lift to provide routin not resident had been in place, so Lift to provide routin not resident had been in place, so Lift to provide routin not resident had been in place, so Lift to provide routin not resident had been in place, so Lift to provide routin not resident had been in place, so Lift to provide routin not resident had been in place, so Lift to provide routin not resident had been in place, so Lift to provide routin not resident had not resid	had not been placed in the ight due to the Arjo Lift would ent high enough to place the ident's bed. Continued the Arjo Lift would allow the ADLS the only change in May 12, 2012, through May 17, dent was not able to lie downed. Further interview her residents did not receive ue to the lift being broken. Insed Practical Nurse (LPN) #1 at 3:15 p.m., in the Activity he Maxi Lift broke on May 12, and was not operational until etime in the morning. Further the facility attempted to contact and the Maintenance Director on Maxi Lift and did not receive in Maxi	F 4	56			

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
		445099				05/23/2012	
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, ATHENS				STREET ADDRESS, CITY, STATE, ZIP CODE 1204 FRYE ST ATHENS, TN 37303			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG			SHOULD BE COMPLETION	
F 456	p.m., in the Activity required total care, the resident stayed staff repositioned to routine care with the been able to lie the Interview with the at 11:30 a.m., in the confirmed the med through 17, 2012, required use of the	A #3 on May 22, 2012, at 3:05 A Room, confirmed the resident A when the Maxi Lift was broken I in the electric chair all day, the resident, staff performed the Arjo Lift, but staff had not the resident down in bed. Administrator on May 22, 2012, the Administrator's office, thanical lift was broken May 12, two residents in the facility the broken lift, and all equipment that is to be reported immediately	F	456			